KCDRB Form #6 **LEOFF-I MEMBER'S CLAIM** REVISED 06-26-02

FOR REIMBURSEMENT OF MEDICAL EXPENSES

(To be completed by LEOFF-I member):

Name:_____ Soc. Sec. No. _____

Address:_____ Date of Birth: _____

_____ Telephone:_____

OTHER SOURCES OF REIMBURSEMENT:_____

Other Insurance Policy No.

MEDICAL CONDITION(S): _____

EXPENSES INCURRED:

Dates of Service	Description of Medical Treatment/Equipment	Name of Provider(s)	Patient's Responsibility **After** Insurance Reimbursement
			$
			$
			$
			$

TOTAL CLAIMED (MINUS INSURANCE REIMBURSEMENT): $ _____

Check "✓" all boxes below that apply to you.

☐ I have attached copies of billing statements, the Statement of Physician/Health Provider (KCDRB Form #7), and other supporting documents.

☐ The condition treated was not brought on by dissipation or abuse and the expenses incurred were solely for necessary medical services.

☐ I understand that it is my responsibility to see to payment of the service provider(s) before charges become delinquent. This claim contains no late charges, interest or missed appointments.

☐ If bills are for services outside my pre-paid health plan, I have explained on a separate sheet attached why reasonably equivalent services were not available. See Board Rule 8.11 A(4).

I HEREBY ATTEST that, to the best of my knowledge, the above information is true and correct. I hereby authorize any service provider who has treated me for this condition to release my medical records to the King County Disability Retirement Board or its designee. Furthermore, I hereby consent to examination by any other physician(s) the Board may require. I understand that this consent is given only for the purpose of establishing my right to LEOFF-I benefits.

Signed:_____ Date: _____

LEOFF-I Member